

**THE MARYLAND PEDIATRIC GROUP, L.L.C./PEDIATRIC CONSULTANTS, P.A.  
FINANCIAL POLICY DISCLOSURE AND AGREEMENT**

*EFFECTIVE APRIL 1, 2010*

*UPDATED MARCH 24, 2011*

*UPDATED APRIL 20, 2011*

Thank you for selecting The Maryland Pediatric Group, L.L.C./Pediatric Consultants P.A. for your pediatric healthcare needs. We would like to take this opportunity to inform you of our practices updated financial responsibilities. These policies protect our ability to successfully provide care and responsibly adhere to mandated guidelines established by patient selected and contracted insurance companies. Your familiarity with the following policy statements and your willingness to comply, are imperative for the delivery of our pediatric care.

**ALL PAYMENTS ARE EXPECTED AT THE TIME OF  
SERVICE PRIOR TO SEEING A PROVIDER:**

The Maryland Pediatric Group, L.L.C./Pediatric Consultants P.A. will begin collecting co-pays and any outstanding patient balances PRIOR to seeing the provider effective April 4<sup>th</sup>, 2011. Co-pays are required at the time of service as dictated by your insurance company. Outstanding patient balances are expected in full unless other arrangements have been made in advance. The Maryland Pediatric Group, LLC/Pediatric Consultants reserves the right to refuse service because of non-payment.

If you send your child into the office with another care giver, (i.e. Grandparents, Nanny, Aunt, Uncle, etc.) please provide that care giver with your insurance card and co-pay to be collected at the time of service. Any patient who is over 18 is expected to pay his/her co-pay and any outstanding balance at time of service.

The Maryland Pediatric Group, L.L.C./Pediatric Consultants P.A. accepts cash, personal check (in-state only), VISA, and/or MasterCard. There is a service charge for returned checks of \$25.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment **prior** to scheduling appointments. Please contact Kass Benchoff, Practice Administrator, to make these payment arrangements.

**INSURANCE:**

We will ask to verify your insurance on EVERY visit. Please make sure to bring your insurance card with you. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We send out patient statements as a courtesy to you. However, if you have an outstanding balance on your account and come into the office to be seen, payment of that balance is expected whether you have received a statement in the mail or not. Keep in mind; you receive your Explanation of Benefits from your insurance company before we receive payment from your insurance company for any date of service. This EOB (explanation of benefits) will explain what your responsibility is to the practice. We are happy to supply you

with a statement while in the office to compare to your explanation of benefits; however, again, payment in full is due PRIOR to being seen.

We will also bill non-participating insurance companies as a courtesy to you. However, payment in full is expected at the time of service. Reimbursement for services rendered will be sent directly to you by the insurance company.

If you need assistance or have questions about insurance related balances, please contact our billing company, EHS, Inc. between 8:00 a.m. and 4:00 p.m., Monday through Friday at 410-785-0333.

**COLLECTION AGENCY:**

Any outstanding balance that is the responsibility of the patient or guarantor that is past due by 60 days may be forwarded to a collection agency. Patient and/or guarantor will be responsible for any costs incurred by the practice with the collection agency in addition to the balance due.

**REFUNDS:**

Overpayments will be refunded upon written request to the responsible party within 30 days.

**MANAGED CARE:**

If you are enrolled in a managed care insurance plan (i.e., HMO), you must have a referral from your primary care physician's office to see a specialist (Pediatric Consultants patients). We will be unable to see you if you do not have a referral at the time service is rendered.

**FORM FEE CHARGES:**

Please see our website for individual form fees.

**MISSED APPOINTMENTS/LATE CANCELLATIONS:**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or appointments not cancelled within 24 hours appointments. The charge for missed appointments is \$25. Excessive abuse of scheduled appointments may result in discharge from the practice.

**MEDICAL SUPPLIES:**

If the practice orders any medical supplies or products related to the scheduled appointment with a provider in our office, the patient and/or the guarantor will be responsible for the cost of the supplies/products in addition to the fee imposed for missed appointments/late cancellations.

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(to be placed in patient's chart)**

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Patient name: \_\_\_\_\_

I have received and understand The Maryland Pediatric Group, L.L.C./Pediatric Consultants, P.A. Financial Policy.

- I agree to assign insurance benefits to The Maryland Pediatric Group, LLC/Pediatric Consultants, P.A. whenever necessary. \_\_\_\_\_ initial
- I agree to pay a co-pay and any outstanding patient balances (if applicable) PRIOR to being seen by a provider. \_\_\_\_\_ initial
- I agree that if it becomes necessary to forward my account to a collection agency because of lack of payment on legitimate patient balances owed to the practice, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. \_\_\_\_\_ initial
- I acknowledge the same responsibility for the siblings of the above mentioned patient. \_\_\_\_\_ initial

Other children seen at this office: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of responsible parent  
guarantor/insured and/or  
authorized representative: \_\_\_\_\_

Relationship to patient(s): \_\_\_\_\_ Date: \_\_\_\_\_

*Updated March, 23, 2011*